

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (2)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07743		07733	
1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>	c. LENGTH OF STAY IN 1b <u>1 week</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> 22-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>608 Washington Lane</u>		d. STREET ADDRESS <u>104 Benjamin Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Raymond Lee Driscoll</u> First Middle Last		4. DATE OF DEATH <u>MAY 30</u> 19 <u>66</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 6 1902</u> 63
9. AGE (In years last birthday) yrs. <u>63</u>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - shirt maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shirt</u>	11. BIRTHPLACE (State or foreign country) <u>Wicomico County</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph R. Driscoll</u>	
14. MOTHER'S MAIDEN NAME <u>Lillie Rounds</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>214-10-90-71</u>		17. INFORMANT <u>Mrs. Ruth Driscoll (wife)</u> Address <u>Salisbury, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, acute</u> 4201 DUE TO (b) <u>ASCVD with coronary disease</u> DUE TO (c) <u>5 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>F. J. Townsend, Jr.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F. J. Townsend, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>MAY 30, 66</u>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>June 1/1966</u>	<u>Parsons Cemetery</u>	<u>Salisbury, Maryland</u>
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY, MARYLAND</u>	
25a. REC'D BY REGISTRAR <u>JUN 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1900

THE

NEW YORK

1900

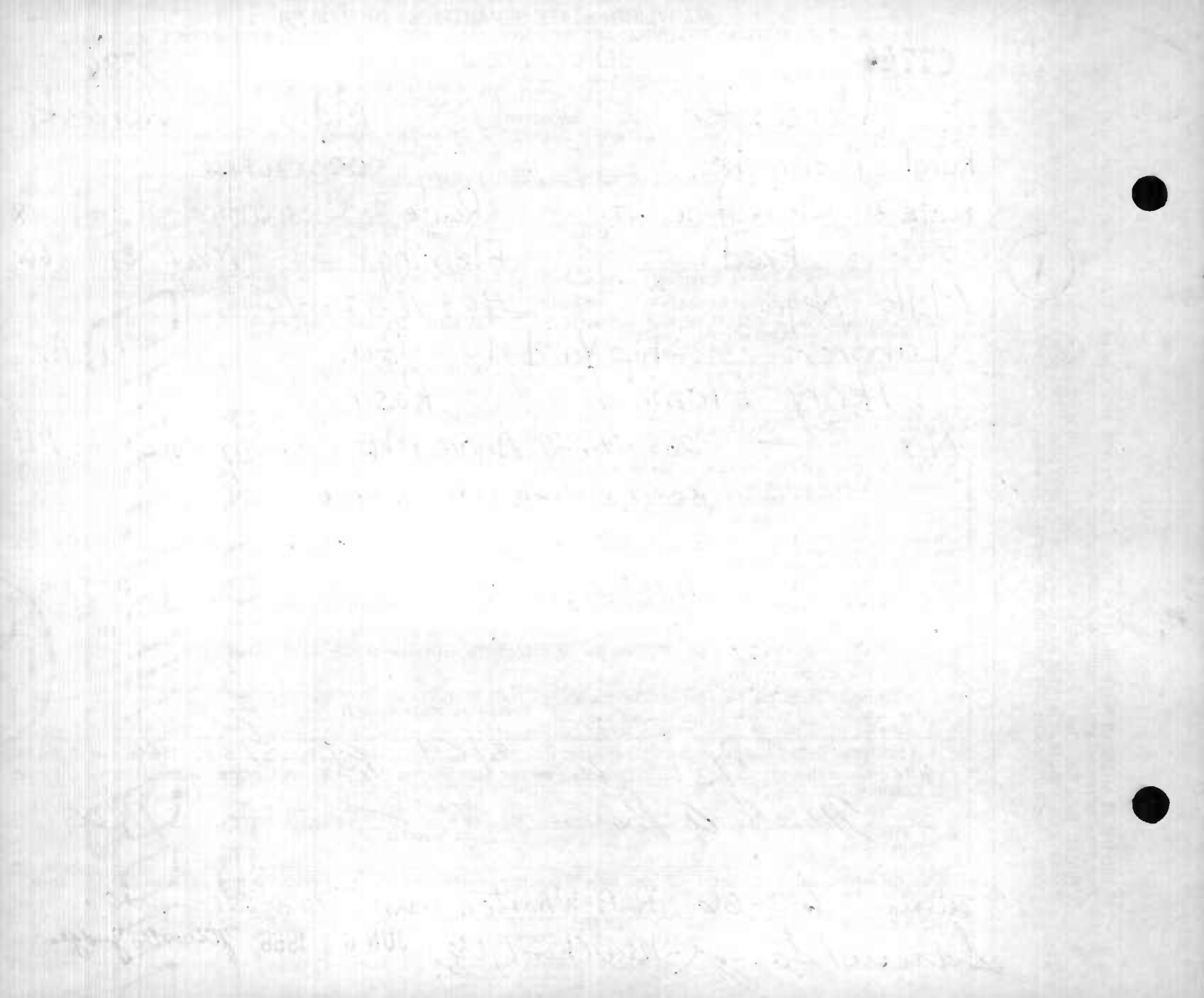
THE NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Pocomoke</u> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Route 2, Clementine St.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> d. STREET ADDRESS <u>Route 2 Clementine St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Fred</u>		4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1966</u>		5. SEX <u>Male</u>							
6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 11, 1923</u>							
9. AGE (In years last birthday) <u>42</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ga.</u>							
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Henry Fleming</u>		14. MOTHER'S MAIDEN NAME <u>Rosa ?</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>265-24-9129</u>		17. INFORMANT <u>Annie Mae Fleming</u> Address <u>Pocomoke, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CARDIAC INFARCTION</u> 260x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOLE SCLEROSIS UNDETER.</u> (c) <u>DIABETIS MEL.</u> 2-3 YRS.PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>3/64</u> , 19 <u>64</u> , to <u>5/31</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/31</u> , 19 <u>66</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>W. A. Baron</u>		22b. DATE SIGNED <u>6/1/66</u>		22c. PHYSICIAN'S NAME (Type) <u>W. A. Baron</u>							
22d. ADDRESS		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-3-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>R. B. Wharton mem. Parkersley, Va.</u>							
23d. LOCATION (City, town or county) (State) <u>Va.</u>		24. FUNERAL DIRECTOR <u>Samuel S. Sarge</u>		25a. REC'D BY REGISTRAR <u>JUN 6 1966</u>							
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS		25d. ADDRESS							



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with with form 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>Item 20 Film G377 6/6/66 77</div> <div>07745</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>07735</div>											
1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin c. LENGTH OF STAY IN 1b Berlin Md.						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS Spring Hill Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Omar First Middle Last Harmon						4. DATE OF DEATH Month 5 Day 25 Year 1966					
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 13, 1907		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Timber work				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Harmon						14. MOTHER'S MAIDEN NAME Laura Hudson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT Nellie Harmon		Address 706 Moor St. Salisbury Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal Injuries 9108 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Accident DUE TO (c) Tree fell on him PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Tree fell on victim crushing him to the ground causing internal injuries and breaking both legs. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year 2:00 p.m. 5/25 1966 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work et work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Timber woods 20f. (City or town) (County) (State) Berlin Worcester Md.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Acting 22. DATE SIGNED 5-25-66											
ACTUAL SIGNATURE Clifford E. Schott				EXAMINER'S NAME (Type) Clifford E. Schott, M.D.				Address (Street, city, town, or county) Worcester			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/29/1966		23c. NAME OF CEMETERY OR CREMATORY St. Marys Church		23d. LOCATION (City, town or county) (State) West Post Office Md.			
24. FUNERAL DIRECTOR Cliff F. Stewart						ADDRESS Salisbury Md.		25a. REC'D BY REGISTRAR JUN 1 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

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VR A15ME
5M 1/63

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

077246

07736

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <u>404-13 Wighton Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Harold W. Parker</u>		4. DATE OF DEATH <u>May 1st</u> 19 <u>66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28, 1915</u>
9. AGE (In years last birthday) <u>50</u>		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u>	
11. IF UNDER 24 HRS. <u>Hours</u> <u>Min.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Victor Parker</u>		14. MOTHER'S MAIDEN NAME <u>Mamie Reid</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service)		16. SOCIAL SECURITY NO. <u>220-16-7620</u>	
17. INFORMANT <u>Elizabeth Parker Snow Hill, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>8919</u> DUE TO <u>Carbon Monoxide Poisoning</u> Conditions, if any, which gave rise to immediate cause (b) <u>8 hrs</u> (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Alcoholism (?)</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell sleep in car</u>	
20c. TIME OF INJURY Month, Day, Year <u>1 May 1966</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 113</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>David R. R. R.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAVID R. R. R.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-07-66</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Shiloh Bapt. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Worcester, Md</u>	
23. FUNERAL DIRECTOR <u>C. C. Humbles</u>		24. REC'D BY REGISTRAR <u>5-4-66</u>	
ADDRESS <u>Accomac, etc.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

INVENT

UNITED STATES DEPARTMENT OF COMMERCE
BUREAU OF PATENT AND TRADEMARKS

OFFICE OF THE COMMISSIONER OF PATENTS AND TRADEMARKS
WASHINGTON, D. C. 20530

Serial No. 1,234,567
Class No. 100
Subclass No. 100

INVENTOR: J. D. ROBERTS
BY: J. D. ROBERTS

WITNESSES: J. D. ROBERTS
J. D. ROBERTS

FILED: MAY 10 1960
FBI

RECEIVED: MAY 10 1960
FBI

INDEXED: MAY 10 1960
FBI

SEARCHED: MAY 10 1960
FBI

SERIALIZED: MAY 10 1960
FBI

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INDEXED: MAY 10 1960
FBI

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07747

CERTIFICATE OF DEATH

07737

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Berlin Nurseing Home				d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Homer W. Shockley		4. DATE OF DEATH May 23 19 66		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1899		9. AGE (In years last birthday) 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Nursery		11. BIRTHPLACE (County & State, or foreign country) Snow Hill, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Isaac W. Shockley		
14. MOTHER'S MAIDEN NAME Theodosia E. Hales			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. 217102370			17. INFORMANT Anna G. Shockley, Ocean City, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Chr. Myocarditis & Endocarditis DUE TO (c) Hypertension					INTERVAL BETWEEN ONSET AND DEATH 3 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 5-5- , 19 66 , to 5-23- , 19 66 , that (I) (we) last saw the deceased alive on 5-23- , 19 66 , and that death occurred at 11:52 M, from causes and on the date stated above.					
22a. SIGNATURE Chas R Law			22b. DATE SIGNED 5-25-1966		
22c. PHYSICIAN'S NAME (Type) Berlin Md			22d. ADDRESS Berlin Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 26/66	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	23d. LOCATION (City or Town) (County) (State) Snow Hill, Maryland		
24. FUNERAL DIRECTOR William H. Thomas			25a. REC'D BY REGISTRAR MAY 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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UNITED STATES OF AMERICA

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07748

07738

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville			
c. LENGTH OF STAY IN 1b Life				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) XX				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Selina Last Smack				4. DATE OF DEATH Month May Day 5 Year 1966			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 4, 1905	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Millie Jarman				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. 219-07-9365				17. INFORMANT Henry Smack Whaleyville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Essential Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 1/2 Yrs. (c) Instant							INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19			
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) deceased attended the deceased from 11/28/59 , 19__, to 4/15/66 , 19__, that (I) was last saw the deceased alive on 4/15/66 , 19__, and that death occurred at 5 PM , from the causes and on the date stated above.			
22a. SIGNATURE Ivory U. Sully, Jr., MD				22b. DATE SIGNED 5/6/66			
22c. PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr., MD				22d. ADDRESS P. O. Box 126, Berlin, Md.			
23a. BURIAL, CREMATION, Burial (Specify)				23b. DATE THEREOF 5/7/66			
23c. NAME OF CEMETERY OR CREMATORY Pulletts Chapel				23d. LOCATION (City, town or county) (State) Whaleyville, Md.			
24. FUNERAL DIRECTOR John Whaley Silbipulle, Del.				25a. REC'D BY REGISTRAR MAY 9 1966			
25b. REGISTRAR'S SIGNATURE Charles Judge				25c. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3836

CENTINITY OF STATE

1974

Instant

General Inspection

General Inspection

Disputed matters

1/25/79

1/25/79

P. O. Box 124, Berlin, Md.

Theresa W. Bell, Jr., MD

Theresa W. Bell, Jr.

MAY 8 1988

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
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07749
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07739

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Ocean City</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Elm Street</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Ocean City</u> d. STREET ADDRESS <u>Elm Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>O'ferall</u> First Middle Last 4. DATE OF DEATH <u>May 12 1966</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-10-1896</u> 9. AGE (In years last birthday) <u>69</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mill work</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Mill work</u> 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Thornton</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>World War I 1917-1918</u>		14. MOTHER'S MAIDEN NAME <u>S. Ella Taylor</u> 16. SOCIAL SECURITY NO. <u>221-09-0592</u> 17. INFORMANT <u>Wm J. Thornton</u> Address <u>Pennsgrove, N.J.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bullet wound - Self inflicted</u> 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Clifford E. Schott</u> EXAMINER'S NAME (Type) <u>Clifford E. Schott, M.D.</u>		22. DATE SIGNED <u>5-14-66</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Acting Address (Street, city, town, or county) <u>Worcester</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-16-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sand Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Georgetown, Del</u>	
24. FUNERAL DIRECTOR <u>Anna A. Burbage</u> ADDRESS <u>Berlin, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 17 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO THE SECRETARY OF THE NAVY
FROM THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum or letter with several paragraphs of text that is mostly illegible due to fading and bleed-through.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07750

CERTIFICATE OF DEATH

07740

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Berlin		c. LENGTH OF STAY IN 1b All Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Berlin	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS Flower Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LILLIE TINGLE		4. DATE OF DEATH Month May Day 10 Year 1966			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-30-1896	9. AGE (in years last birthday) 69/10/1 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Worcester	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Lillie Adams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-18-5731		17. INFORMANT Ressie Holland Address Branch St, Berlin, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic nephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility					INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs 3 yrs
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1/7/83 , 19 to 5/1/66 , 19, that (I) had last saw the deceased alive on 5/1/66 , 19, and that death occurred at 7 AM , from the causes and on the date stated above.					
22a. SIGNATURE Ivory U. Sully, Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/11/66	
22c. PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr., MD		22d. ADDRESS P. O. Box 126, Berlin, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-14-66		23c. NAME OF CEMETERY OR CREMATORY Emmerson	
23d. LOCATION (City, town or county) (State) Berlin, Md					
24. FUNERAL DIRECTOR Horatio B. Jolley - Jersey Rd. Salisbury		ADDRESS		25a. REC'D BY REGISTRAR MAY 19 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge					

03751

MAY 19 1966

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07751

CERTIFICATE OF DEATH

07748

1. PLACE OF BIRTH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Golf Course Rd		d. STREET ADDRESS Golf Course Rd.	
3. NAME OF DECEASED (Type or print) James B. Whaley		4. DATE OF DEATH Month May Day 22 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10 1893
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) Whaleyville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benton H. Whaley		14. MOTHER'S MAIDEN NAME Edna Staton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Emily U. Whaley, Ocean City, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crown artery disease 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) ASCU with coronary sclerosis DUE TO (c) 6 years		INTERVAL BETWEEN ONSET AND DEATH 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 , 19 May , 19 66 , that (I) (we) last saw the deceased alive on May 16 19 66 , and that death occurred at 7:45 M, from causes and on the date stated above			
22a. SIGNATURE F. J. Townsend, Jr.		22b. DATE SIGNED May 23, 66	
22c. PHYSICIAN'S NAME (Type) F. J. Townsend, Jr.		22d. ADDRESS Ocean City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/24/66	
23c. NAME OF CEMETERY OR CREMATORY Whaley Cemetery		23d. LOCATION (City or Town) (County) (State) Whaleyville, Maryland	
24. FUNERAL DIRECTOR Snow Hill, Maryland		25a. REC'D BY REGISTRAR MAY 27 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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20 M 1/65

1270

CERTIFICATE OF DEATH

07752

07742

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>WOR.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Bishop</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Bishop</u> 23-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Old Stage Road</u>		d. STREET ADDRESS <u>Old Stage Road.</u>	
3. NAME OF DECEASED (Type or print) <u>Delmar James Wilkins</u>		4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28 1916</u> 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WEIGHMASTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHICKEN</u>	11. BIRTHPLACE (County & State, or foreign country) <u>DELAWARE</u>
13. FATHER'S NAME <u>JAMES WILKINS</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>221-09-2839</u>	
17. INFORMANT <u>MRS BERTIE WILKINS, Wife, Bishop, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>CORONARY OCCLUSION, ACUTE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>ASCVD</u> DUE TO (c) <u>5 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , 19 <u>66</u> to <u>1966</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 28</u> 19 <u>66</u> , and that death occurred at <u>1966</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>F. J. Townsend, Jr</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>F. J. Townsend, Jr</u>		22d. ADDRESS <u>Ocean City, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5-8-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ODD FELLOWS CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>Bishopville, Maryland</u>
24. FUNERAL DIRECTOR <u>C. Douglas Nelson, Frankford</u>		25a. REC'D BY REGISTRAR <u>DA MAY 12 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1000

CERTIFICATE OF DEATH

1000

Name of Deceased		Date of Death	
John Doe		10/10/1910	
Age		35	
Sex		Male	
Marital Status		Single	
Cause of Death		Diphtheria	
Place of Death		Home	
Signature of Physician		J. H. Smith	
Signature of Registrar		A. B. Jones	
Date of Registration		10/15/1910	
Place of Registration		City of New York	